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Social Factors and Recovery from Mental Health Difficulties: A Review of the Evidence

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Abstract

Although there is now increasing evidence as to the role played by social factors in contributing to the onset of mental health difficulties, there has been little systematic examination of the role that social factors can play in enabling (or impeding) recovery. This paper provides a review of the emerging international literature in this area, and is linked to a wider conceptual review undertaken as part of a major project researching recovery practice in the UK. Research findings are explored in detail in relation to three areas that had been identified by the wider review as central to recovery: empowerment and control over one's life; connectedness (including both inter-personal relationships and social inclusion); and rebuilding positive identities (often within the context of stigma and discrimination). Out of this emerges a clearer picture of the importance of particular social factors, which starts to define

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a more broad-based and proactive agenda for mental health social work—with an emphasis not just on working with individuals, but also on engaging with families and communities. However, there is a need for further research and development work in order to determine how to intervene most effectively in order to influence specific social factors.

Keywords: Empowerment, identity, mental health, recovery, social inclusion

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Introduction

Over recent years, there has been a growing focus on recovery within mental health services (Slade, 2009). Developed from within the survivor movement, this concept of recovery is conceptually distinct from any medical definition of remission of symptoms. Instead, it emphasises rebuilding a worthwhile life, irrespective of whether or not one may continue to have particular distress experiences—and central to this can be reclaiming valued social roles *and* a positive self-identity (Social Care Institute for Excellence *et al.*, 2007). Interestingly, steps towards 'social' recovery, such as entering mainstream employment, have been shown to lead towards a reduction in symptoms for many people (Burns *et al.*, 2009), and this links to wider evidence that both 'social' and 'clinical' recovery rates correlate much more closely with socio-economic factors, such as employment rates or cultural contexts, than they do with any advances in medical treatment (Warner, 1994).

Recovery may involve a journey both of personal change and of social (re)engagement—which highlights the importance of creating accepting and enabling social environments within which recovery may be supported. This links with the social model of disability in focusing on wider processes in the social mainstream in which markers of social difference may be used to exclude and discriminate against those with impairments (Beresford, 2002)—with mental distress sometimes being associated with particularly extreme forms of stigmatisation. However, while there is a substantial body of research that shows how important social factors can be in contributing to the incidence of mental health difficulties (Tew, 2011), there is less clarity as to how social factors may also play a central role in people's recovery.

At the start of a five-year programme of recovery research in England (the REFOCUS Study funded by the National Institute for Health Research), a systematic review of published descriptions and models of personal recovery was undertaken. Ninety-seven papers were included from 5,208 papers identified and 366 reviewed. Emergent themes were extracted from each narrative description and these were then collated and compared

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using inductive, open coding techniques. The main over-arching themes and related sub-themes were identified—out of which was developed an empirically based conceptual framework by which to understand what may be involved in recovery. (For a fuller description of this methodology, see Leamy *et al.*, in press.)

The resulting conceptual framework comprised five interlinking Recovery Processes:

- empowerment and reclaiming control over one's life;
- rebuilding positive personal and social identities (including dealing with the impact of stigma and discrimination);
- connectedness (including both personal and family relationships, and wider aspects of social inclusion);
- hope and optimism about the future;
- finding meaning and purpose in life.

While all of these processes may link with the social aspects of people's experience, it is the first three that would seem particularly social in their conception. This article develops a more detailed review of the literature relating to each of these Recovery Processes and how particular forms of social intervention may be enabling of them.

Both in the UK and internationally, social work has yet fully to embrace the opportunities presented by the emerging recovery paradigm and move beyond a reactive practice that focuses on immediate concerns of need and risk (Ramon, 2009). By clarifying the relevance of social factors and, by implication, social interventions, an evidence base for a more positive social work practice may be developed—one that would enable practitioners to champion the relevance of the social within multidisciplinary recovery practice.

Searching the literature

As this is not a well-established field of research with commonly agreed terminologies, relying exclusively on particular search terms might lead to the exclusion of some potentially relevant literature. Therefore, following Morgan *et al.* (2007), a more pragmatic approach was used that built on the REFOCUS systematic review but also utilised other search strategies. Given the inherent complexity of researching the social aspects of mental health (Tew *et al.*, 2006), no a priori assumptions were made in terms of privileging evidence derived using particular methodologies such as randomised controlled trials.

The electronic database search used for the REFOCUS systematic review on recovery used an array of possible terms to define the population of interest (such as 'mental health', 'mental illness' or 'psychological problem') in combination with the stem 'recover' (to include 'recovery'

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or 'recovering'). For a full description of the protocol, see Leamy *et al.* (in press). For this study, these terms were augmented by the inclusion of the term 'social' identified from title, abstract, keywords or subject headings. This search was run in the following twelve bibliographic databases (AMED, British Nursing index, EMBASE, MEDLINE, PsycINFO, Social Science Policy, CINAHL, International Bibliography of Social Science, ASSIA, British Humanities Index, Sociological Abstracts, and Social Services Abstracts), all of which were searched from inception to December 2009. In addition to these searches, a search of Social Care Online was conducted using the terms 'mental health' and 'recovery'. Finally, all searches were cross-checked against a recent literature search conducted by the Centre for Mental Health Recovery (Ramon, 2010) and co-authors were invited to use their respective disciplinary expertise to identify any additional papers that they considered relevant.

As our focus was on the evidence linking social factors to recovery and on recovery practice, theoretical and policy papers were excluded. With current conceptions of recovery just starting to take hold in the early 1990s, only papers from 1995 onwards were included. This left a total of seventy-one journal papers for review. Around half of the literature originated in the USA or Canada, with the rest from the UK (31 per cent) and Europe (19 per cent). It reflected a broad range of disciplinary orientations, with around 15 per cent being located within social work or social care and the rest divided between psychology, psychiatry and occupational therapy, or reflecting inter-disciplinary collaborations.

All of the papers were found to relate to one or more of the social aspects of recovery that emerged from the REFOCUS systematic review. Around half of the papers addressed aspects of connectedness and a third addressed identity issues (mainly from the perspective of stigma), with under a fifth explicitly addressing empowerment. These were then coded on the basis of emergent themes—see Table 1.

As relatively few journal papers were identified in relation to black and minority ethnic experience, community development and self-directed support, four additional research reports were also included.

Power relations and empowerment

An analysis of the social factors that contribute to mental health difficulties can reveal underlying themes of powerlessness, injustice, abuse or 'social defeat' (Gilbert and Allen, 1998; Tew, 2011). Such experiences may be exacerbated by coercive or paternalistic service responses that may further undermine people's sense that they can exercise any form of competent agency (Hughes *et al.*, 2009). If people are to move on from such disabling social situations, they may need support in changing their social context from one in which they may feel stuck within power relations

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Table 1 Emergent themes

Recovery processes	Empowerment	Identity	Connectedness
Emergent themes	(1) Self-efficacy (2) Power together with others (3) Strengths approach (4) Self-directed support (5) Peer-organised services	(1) Social identities (2) Discrimination (race, gender, etc.) (3) Mental illness stigma (4) Anti-stigma/anti-discriminatory interventions	(1) Inter-personal relationships (2) Family/systems approaches (3) Social inclusion (4) Occupation and employment (5) Community development

that are limiting or oppressive to one in which they may feel more empowered (Tew, 2002).

Within the research literature on empowerment and recovery that was reviewed, there were differences in emphasis between a more individualistic focus on identity and self-efficacy and a more collective approach that explored the mobilisation of power in relationships with others. In a qualitative study, Mancini (2007) found that 'at the heart of the recovery process was the transformation from an illness-dominated identity to an identity of agency [and] competence' (Mancini, 2007, p. 50). Using more of a relational 'self in community' focus, Nelson *et al.* (2001) explored how 'increased control over daily life' emerged within the context of 'supportive and equitable relationships' with peers, family and friends, and 'participation in the community-at-large' (Nelson *et al.*, 2001, pp. 131–8). Both perspectives may be important and, building on a consensus exercise involving survivor activists, Judi Chamberlin proposed a working definition of empowerment that combines 'both an individual and a group dimension' and involves 'effecting change in one's life and one's community' (Chamberlin, 1997, pp. 43–4).

Although power has to be constructed by people themselves, practitioners can facilitate this process. One approach is to enable people to identity their strengths and resources—and those within their social environment (see Saleebey, 2002). Within the context of this review, a strengths approach has been shown not just to contribute to social recovery, but also to a major reduction in symptomatology compared to a more conventional assertive outreach approach (Barry *et al.*, 2003). It is suggested that such approaches may be particularly relevant to supporting recovery within minority communities (Jones *et al.*, 2007).

A complementary approach by which to enable empowerment is that of self-directed support, in which a person is allocated an individual budget and has considerable discretion as to how they may use this in enabling them to live a full and socially interdependent life. Initial evaluations of

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pilots in England suggest that those participating in the scheme found that this gave them greater choice and control (Spandler and Vick, 2006; Rabiee *et al.*, 2009) and this mirrors experience in the USA (Alakeson, 2007). Many social workers in England are now responsible for supporting service users wishing to use individual budgets, enabling them to build on their strengths and abilities in organising their support arrangements. However, the individualisation inherent in this approach may also present certain pitfalls in terms of potentially isolating people from opportunities to develop power through peer relationships.

Service user-run, self-help or mutual support activities have the potential to counter this tendency. Unlike conventional mental health services, these offer a more egalitarian and less hierarchical approach, with opportunities for influence (Brown *et al.*, 2008), and to develop 'power together' with others. In the UK, a leading example is the Hearing Voices Network (*http://www.hearing-voices.org*) that provides accepting environments in which voice-hearers can support each other in regaining power over their lives through sharing strategies for understanding and managing their voices. An evaluation found that participants regained power through solidarity and establishing more positive identities (Meddings, 1998)—a finding that is supported by other evaluations of peer-provided services (Rogers *et al.*, 2007; Resnick and Rosenheck, 2008).

Social workers can play a key role in enabling people to develop their strengths and abilities, and in facilitating opportunities for mutual support. Recent UK examples of such approaches include social workers organising a training course for service users wishing to become peer support workers (as a result of which many have now found paid work in such roles) and developing a network of 'experts in experience' who have progressed to becoming educators or acting as advisors for research projects or in service commissioning.

Identity, discrimination and stigma

Mental health crises can dislocate people's sense of both who they are and how they are perceived by others—and rebuilding positive personal and social identities can be a core component of recovery (Petty and Triolo, 1999).

Processes of social oppression relating to people's identities are linked to a substantially higher incidence of mental health difficulties, such as for certain ethnic minority groups (Fearon *et al.*, 2006) and those who are lesbian, gay or bisexual (Jorm *et al.*, 2002). However, there is very little research evidence on the experience of recovery *within the context of* ongoing social discrimination—and this is an important gap that needs to be filled by further research.

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Within a study of African American experience, participants seemed unable to distinguish whether the prejudicial responses they encountered in their social interactions were on the basis of their race or their mental illness (Armour *et al.*, 2009), suggesting that their experience of oppression may be so pervasive that making such distinctions may be difficult. Participants' comments contained in one research report addressing the experience of black individuals in England also made surprisingly little reference to this question, although stigma and discrimination were identified as barriers to recovery by some of the participants (Southside Partnership/Fanon, 2008). A Scottish report suggested that pre-existing racial discrimination intensified the experience of stigma associated with mental health difficulties—and people's recovery processes involved having to deal with both (Scottish Recovery Network, 2008).

In relation to gender, a study has explored how men in recovery reconstruct valued social identities within the context of dominant constructions of masculinity—where it can be precisely these constructions that may have contributed to their mental health difficulties in the first place. Depending on the social support available to them, some men felt able to resist elements of hegemonic masculinity while others subverted narrative terms (such as 'being one of the boys') in support of what might appear as 'feminised' aspects of their identities (Emslie *et al.*, 2006). There is an urgent need for parallel research on how women negotiate potentially oppressive gender stereotypes within their recovery journeys—potentially drawing upon a broader context of feminist research and practice, both within social work and more widely.

Over and above these aspects of discrimination, people with mental health difficulties may also suffer social stigmatisation that may be at least as disabling as the difficulties themselves (Corrigan and Penn, 1997)—and may actually cause these difficulties to become worse (Van Zelst, 2009). There is strong evidence that people with mental health difficulties are subject to widespread social exclusion at a structural level—such as with respect to housing and employment—reflecting organisational policies and practices that may have intentionally or unintentionally discriminatory consequences (Corrigan *et al.*, 2004). Stigmatisation may affect not just people with mental health difficulties, but also, by association, their families (Struening *et al.*, 2001).

Recent research has provided more detailed findings as to exactly how stigmatisation may impact upon people and the implications of this for recovery. The internalisation of stigma within one's self-identity has been shown to act as a barrier to recovery through undermining self-esteem and hope (Link *et al.*, 2001; Yanos *et al.*, 2008), self-efficacy (Kleim *et al.*, 2008) and confidence to take part in mainstream social interactions (Perlick *et al.*, 2001). Nevertheless, some people successfully deploy strategies of 'stigma resistance' and are able to reject the legitimacy of social discrimination (Rusch *et al.*, 2006). Stigma resistance would seem to depend on

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maintaining affirmative social relationships outside the mental health system, but may be undermined where people are inducted into the identities, roles and expectations associated with being a 'mental patient' through processes such as hospitalisation, medical diagnosis and risk assessment (Sibitz *et al.*, 2009; Lysaker *et al.*, 2006).

Potential strategies for reducing the adverse impact of discrimination and social stigmatisation on recovery may include:

- community-level initiatives targeting mainstream attitudes and behaviour;
- working alongside people to maximise their capacity to resist or deal with social processes that potentially devalue their identities; and
- identifying and challenging the inadvertent stigmatising impact of many professional practices (Corrigan, 2004; Kondrat and Teater, 2009).

These are approaches in which social workers and other socially oriented mental health practitioners may readily be involved—and which may be particularly cost and time-effective ways of supporting recovery outcomes.

Unfortunately, the evaluation of 'what works' in terms of community-level anti-discriminatory interventions is still somewhat in its infancy. Advocacy and lobby groups may be influential at a policy level in arguing for a review of policies and practices (Corrigan, 2004) and, at a more local level, equalities and disability legislation may be important as levers in challenging discriminatory practices and arguing for 'reasonable adjustments'—particularly at an organisational level such as in workplaces (Thornicroft *et al.*, 2008). However, the implementation of such approaches has yet to be reviewed in any detail.

In relation to stigma, there is little evidence so far that large-scale media campaigns are effective in changing attitudes or behaviour: it would seem that it is more direct and targeted forms of engagement that have the potential to bring about change (Corrigan, 2004). Approaches based on social marketing are increasingly popular, seeking to connect with the specific worldview and identified concerns of 'sub-audiences' in order to tailor forms of engagement that are congruent with this—perhaps by working through local Action Committees that include both influential opinion formers and people with direct experience of mental health difficulties (Warner, 2005). Such programmes aim to increase awareness of mental health issues and to reduce the preference of people within the social mainstream to maintain social distance from those with mental health difficulties.

In both developing awareness and decreasing the tendency of people with mental health difficulties to be seen as 'other', the key ingredients for attitudinal change would appear to be personal contact, opportunities for dialogue and hearing the stories of people with mental health difficulties (Pinfold *et al.*, 2005). Although it may seem easier to engage with those who may be seen as more amenable to change, such as schoolchildren, it is important also to engage with those in positions of power who act as

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gatekeepers for inclusion within mainstream social networks and activities—such as employers, landlords and education providers (Corrigan, 2004).

Our literature search produced only one paper that focused specifically on social interventions in relation to internalised stigma (Kondrat and Teater, 2009). With the aid of a social work case example, this explored the use of narrative approaches to enable a person to 're-story' their identity: working from their own ways of understanding their experience to separate out an active authoring self from its conflation with an objectified and stigmatised 'illness' identity that had been imposed by 'others'. This empowered the person to rebuild relationships with family and community—no longer transacting from an alienated and victimised identity.

Given the emerging research evidence on 'stigma resistance', it will be important to develop social interventions that help a person not to become engulfed in a devalued 'illness' identity and to be able to challenge the legitimacy of stigmatising or discriminatory processes. One such strategy would be mobilising services and resources in the community to minimise the use of hospitalisation and thereby maintain people's connections with, and valued roles within, mainstream family and social networks—as is being tried with some success in Early Intervention services (Fowler *et al.*, 2009).

Connectedness (1): inter-personal relationships

Relationships are vital to recovery: they shape identity, and contribute to or hinder well-being (Mezzina *et al.*, 2006)—and having one or more personal relationships that provide hope and encouragement can be a critical factor in achieving recovery (Spaniol *et al.*, 2002). However, people with mental health difficulties often find themselves with fewer close relationships (Macdonald *et al.*, 2005) and not all relationships and social interactions are experienced as positive or supportive of recovery (Yanos *et al.*, 2001). People may feel disempowered or stigmatised by particular others, or by members of the wider community. Such humiliating experiences were seen by participants in a qualitative study as leading to a worsening of their problems and a tendency to withdraw from social contact (Topor *et al.*, 2006).

Over and above this, people may also find certain relationships stressful if they experience intrusive over-involvement or consistent patterns of criticism and hostility, or a lack of warmth and appreciative comments. Across a range of studies, this has been shown to greatly increase the likelihood of relapse (Hooley, 2007). Somewhat unhelpfully, this has been described as 'high expressed emotion', even though it can sometimes be the inability to express warmth that can be the problem—and the precise construction of

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what is problematic may depend on cultural context (López *et al.*, 2004). It is important to recognise that problematic relationship styles may reflect the low self-esteem of carers or others (Kuipers *et al.*, 2006)—indicating that they, too, may need personal support if the relationship, as well as the person with mental health difficulties, is to be enabled to recover.

Other research has sought to tease out what relationship characteristics may be enabling of recovery. What may be important may change during the process of recovery, with qualities of 'standing alongside' and 'being there' appearing important in the earlier stages, and an ability to shift towards greater equality and reciprocity being crucial as people's journeys progress (Topor *et al.*, 2006). What may get in the way of such relationships are social contexts and expectations that create 'feelings of guilt, shame and anger' (Topor *et al.*, 2006, p. 36). Also important to recovery were relationships that situate the person as someone with abilities and where interactions provide 'concrete experiences of being able to exert influence'—offering opportunities to rediscover personal agency and efficacy (Schon *et al.*, 2009, p. 345).

While there is now strong evidence that systemic and family therapy approaches can be effective in reducing the likelihood of relapse (Pilling *et al.*, 2002; Asen, 2002), this work has remained somewhat separated off from recovery practice and can still be organised around a 'living with a chronic illness' model rather than one that is explicitly oriented towards recovery (Glynn *et al.*, 2006). In particular, it would benefit from a more explicit focus on how to support people in changing the terms of their relationships from the more one-sided (if respectful) nature of 'standing alongside' to enabling the person with mental health difficulties to move into a position of increasing autonomy and reciprocity—with the positive risk-taking that is required by both parties if this is to happen. For social workers, this may entail working as closely with informal carers as with service users if such changes in relationships are to be supported.

As well as working to improve existing relationships, there is a need for social interventions to enable people to develop new personal relationships, particularly if they have become socially isolated. While there are expectations that this is something that social workers should be able to do (Huxley *et al.*, 2009), there is no clarity as to how to do this effectively. Support workers may fill this gap in terms of providing consistent and affirmative relationships (Huxley *et al.*, 2009), but there is little research that explores whether (and how) having a support worker may be the springboard for people to develop a wider circle of personal friendships, or whether people may come to depend on this person as their only confidant. An alternative approach that has been evaluated positively by participants is that of a friendship programme in which people are matched with volunteers from the community (McCorkle *et al.*, 2009).

In practice, many people develop peer relationships with others who have experienced mental health difficulties, often finding opportunities for

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acceptance and understanding (and an absence of stigmatisation) that they may not find elsewhere (Mead and MacNeil, 2006). Some such relationships are developed incidentally through encounters within mental heath service settings, while others are encouraged through services that deliberately set out to foster peer support. While many find peer relationships a valuable contributor to their recovery and well-being, some voice concerns that too much of their life may become invested within the world of mental heath, and desire more opportunities to develop relationships within the social mainstream (Angell, 2003).

Connectedness (2): social capital and social inclusion

Social inclusion involves both an active form of citizenship (Ware *et al.*, 2007) and a subjective sense of belonging (Prince and Gerber, 2005)—both of which may result from being part of mainstream social networks and connections (social capital), and engaging in meaningful social and occupational activities within the community. Barriers to social inclusion include not just social stigma and discrimination (as discussed earlier), but also practical issues that may arise as a consequence of people's mental health difficulties, such as low income, unemployment or poor housing (Bradshaw *et al.*, 2007; Mattsson *et al.*, 2008; Wright and Kloos, 2007).

A number of studies have found that both size of social network and respondents' subjective rating of its supportiveness are predictors of recovery outcomes (Corrigan and Phelan, 2004; Mattsson *et al.*, 2008; Hendryx *et al.*, 2009). In general, living with a partner or as part of a family can be helpful in maintaining wider networks of social capital—and those living alone are at greater risk of social isolation and poorer outcome (Salokangas, 1997). However, the beneficial effect of network size can level off once a certain size is reached (Becker *et al.*, 1998)—and it is possible that, for some people with mental health difficulties, maintaining a large network of social connections may become positively stressful, as they may need to withdraw at times in order to regulate their level of stimulation (Boydell *et al.*, 2002).

While some research on employment support has tended to see it as an end in itself, it is important to explore how it may contribute to processes of recovery. Both paid and voluntary employment can result in a larger social network and provide 'a context for establishing and maintaining not only instrumental but also intimate relationships' (Ruesch *et al.*, 2004, p. 692). It can also enable people to take on the positive and socially engaged identity of 'active worker' rather than 'passive patient' and stimulate a sense of belonging within and being connected to the community 'instead of being one of "them"' (Borg and Kristiansen, 2008, p. 517). However, although, for many, it can contribute to the development of their self-esteem and self-confidence, some may find it more of an

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additional burden, particularly if they already feel stressed and disempowered in other aspects of their lives (Provencher *et al.*, 2002).

The evidence in relation to participation in other occupational and community-based activities is more mixed. While one study found this correlated with better recovery outcomes (Hendryx *et al.*, 2009), another found that, unlike work, this did not improve levels of functioning (Eklund *et al.*, 2004)—which suggests that undertaking activities just for the sake of it may not always be beneficial. What may be crucial is the element of choice: 'having more than one alternative available for social inclusion' (Mezzina *et al.*, 2006, p. 72). It is where people are involved in activities that they regard as meaningful that a sense of personal fulfilment and connection to the outside world can be achieved (Smith, 2000).

Although this discussion would suggest that practice specifically geared towards promoting social support and social inclusion is central to the recovery enterprise, our review of the literature has revealed little evaluation of specific social interventions by which to achieve this. Broadly speaking, two complementary approaches are possible: working with those with mental health difficulties to improve their access to social capital and social activities; and working with communities to improve their inclusiveness. However, within the UK context, the increasingly individualised focus of practice in many agencies has resulted in social workers no longer having the scope to engage at a community level, even though failure to do this may render their work with individuals less effective.

Work with communities may involve not just opening doors so that people with mental health difficulties may access existing social networks and activities, but also initiatives to enhance levels of social capital within the community as a whole. Successful community development initiatives generally involve 'light touch facilitation'—bringing people together in ways that allow them to feel that they have ownership of any new social infrastructures (such as groups or activities) that are developed (Seebohm and Gilchrist, 2008). One study found that interventions that promote community safety were particularly important in facilitating the ability of people with mental health difficulties to go out into and participate within their communities (Whitley and Prince, 2005).

Although only one paper sought to operationalise concepts of social capital, there is some evidence that promoting individual-level bonding and bridging social capital can result in improved mental health for those who may otherwise tend to be more socially isolated (Malmberg-Heimonen, 2010). Within a social work context, this involves 'mediating connections between individuals and their impinging, available or potentially achievable' social environments (Farone, 2006, p. 32). Although such approaches are now being implemented in practice, there has so far been little review of their effectiveness.

While participation in user-run services may be enabling of empowerment and the development of supportive personal relationships, this does

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not always provide a springboard to wider social inclusion (Hardiman and Segal, 2003; Pernice-Duca and Onaga, 2009). It is possible that such provision may sometimes act as a long-term alternative to mainstream social participation—which may benefit some, but serve to hold back others (as has sometimes been the case with more traditional forms of day-care provision).

Conclusions for socially oriented recovery practice

There is now substantial evidence about some of the key social factors that may promote (or inhibit) recovery, in terms of empowerment and negotiating positive social identities, supportive personal relationships and social inclusion. However, less research has so far been conducted in relation to 'what works' in terms of specific interventions that may influence these factors and thereby enable processes of recovery.

An important area for development is in harnessing the possibilities for empowerment provided by the implementation of models of self-directed support and personal budgets—which could also act as a lever for the development of mutual support and user-run services. However, it is important to ensure that these do not just provide inward-looking 'safe havens', but form part of a wider fabric of social inclusion. Central to this is foregrounding issues of identity, stigma and discrimination and finding ways in which service users, family, friends and practitioners can work collaboratively both to challenge and to resist the corrosive impact of social oppression.

It is clear that relationships are central to recovery and that relationship needs differ from person to person—so we should be cautious of standardised approaches and any assumptions that all relationships or forms of social inclusion are necessarily good for people. Nevertheless, supporting the development of positive relationships *is* supporting recovery, because it connects people with their social world. To achieve this, a fundamental paradigm shift is required away from an individualised 'treatment-oriented' practice to one in which working with family and friends, and promoting social inclusion, are no longer optional extras. In turn, this requires a theoretical and practical engagement with perspectives that focus on enabling people to maintain as much of their ordinary life identities and connections as possible—and minimising the potentially negative social impacts of hospitalisation and becoming immersed within the world of mental health services.

The framework of evidence that emerges from this review starts to define a clearer agenda as to where social inputs may make a major difference in enabling recovery outcomes, with a primary emphasis on empowerment, relationships and social inclusion. This offers a vision as to the positive role that social work could play within a modern recovery-oriented mental health service. Investing in such activity would require some diversion of

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focus away from more reactive tasks, such as safeguarding and risk management, in order to take a more proactive role in enabling people to achieve their social aspirations—and deal with the potentially adverse impact of ongoing stigma and discrimination. It involves a shift from the individualising focus that has become more dominant in recent years towards a twin-track approach that involves not just direct work with service users, but also developmental work with families, social systems and communities.

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